FROM THE CARIBBEAN

Building Global and National Health Infrastructure in the Wake of COVID

On May 27, 2021, a discussion of health security for all nations was held on the Facebook livestream weekly, hour-long program "A Story Club," based in Trinidad and Tobago, hosted by Dr. Kirk Meighoo, with three online guests, Dr. Joycelyn Elders, Dr. Tim Gopeesingh, and Marcia Merry Baker. Excerpts follow.

Kirk Meighoo: Welcome to Season 2, Episode 2 of "A Story Club; Global Politics and Cultures," brought to you by Bulletproof Podcast Formula. This is a unique venture, streaming simultaneously from Trinidad and Tobago in the Caribbean, Dehradun in India, and San Francisco in the United States. Today's episode is titled, "Building Global and National Health Infrastructure in the Wake of COVID." I'll start off with a quote:

"The only way that the prolonged COVID-19 pandemic can be stopped, is by rethinking the solution. We must have modern health care systems in every country. This means infrastructure for public health and for medical care delivery at modern standards to all populations. One model for this is the U.S. Hill-Burton Act (Hospital Survey and Construction Act of 1946), whose principle was to state how many hospital beds per 1,000 residents must be in each locality. At the time it was 4.5. And deploy accordingly to build them, including modern equipment and staff.

"Look at instances of our ability to do this today. The 1,000-bed Huoshenshan hospital was built in 12 days in Wuhan in 2020. In the U.S., multiple field hospitals were built in record time last spring by the U.S. Army Corps of Engineers. We must do this simultaneously around the world. This means that all countries must work together to accomplish this. We must put aside tensions and conflicts for the time being. There are new

Courtesy of Kirk Meighoo

Participants in a discussion of health security for all nations, on the livestream weekly program, "A Story Club," from Trinidad and Tobago, May 27, 2021. Clockwise from upper right: Dr. Kirk Meighoo (host), Dr. Joycelyn Elders, Dr. Tim Gopeesingh, and Marcia Merry Baker.

strains of SARS-CoV-2 that are showing up that are more aggressive and more transmissible. These can make vaccines obsolete. Thus, our response to the pandemic, seen in these terms, is a question of existential importance to the human species, and requires cooperation of all major industrialized nations."

That was a quote from a statement by the Committee for the Coincidence of Opposites, for the Global Health Summit in Rome, May 21, 2021, and for general circulation.

Today, I am so pleased and honored to have as our guest Dr. Joycelyn Elders, one of the initiators of this Committee for the Coincidence of Opposites. She is also a former U.S. Surgeon General; the first African-American and the second woman to hold that post, serving under Bill Clinton. She's a professor emeritus of pediatrics at the University of Arkansas for Medical Sciences, and a pediatrician.

Courtesy of Kirk Meighoo

Dr. Kirk Meighoo, political analyst, media commentator, author, and former independent Senator in Trinidad and Tobago, who hosted the program.

Our other guest is Dr. Tim Gopeesingh, former Cabinet Minister in the government of Trinidad and Tobago, former Clinical Dean of the Faculty of Medical Sciences at the University of the West Indies, and a gynecologic oncologist.

And finally, we have Marcia Merry-Baker, the Economics Co-Editor of the *Executive Intelligence Review* news service, and also a co-author of the statement I just read from.

Meighoo: I'd like to start off with Dr. Joycelyn Elders. Please let us know a bit more about your background and your interest in medicine and health, and how politics fits into this in your trajectory.

Elders: My background is very unusual in that I grew up in a very small town of 98 people—a farm community. I never saw a doctor until I started college at Philander Smith College. People often ask me: Did I always want to be a doctor and do certain things? But I remind them that you can't be what you can't see. I was born during the time—talk about Zoom—when we barely had radio. I was born in the '30s. We didn't have television, and out in the country, we didn't have it until much later. I know about being rural. I know about being very poor. I know about suffering, and I know about the lack of the kind of quality health care that we need, and about hunger. So, I've experienced most of the things that we talk about in regards to *social determinants* of health. We know that the social determinants are sometimes much greater than the doctoring.

Meighoo: It's Arkansas you're from, right? And the town you're from wasn't even on the map; right?

Elders: The population was 99; 98 when I was in Little Rock! So, you know I understand rural. And I understand lack of transportation; I understand water. We didn't have running water. It was late before we even got electricity. We had kerosene lamplight. So, when we talk about all of the problems that go to make up health, those are the social determinants that are all critical in order to deal with the problem of health across the country. I remember when they had the Hill-Burton Act. And when we talk now, we're able to do medicine in a much more sophisticated way. We need modern hospitals; we've got better and more facilities. We don't necessarily need as many beds as we used to need, because we don't keep people in the hospital that long. We can treat them better, we have better medications to cure them better, so things go better.

Meighoo: How did you get involved in politics? Your path in medicine is very interesting and path-breaking. And it was a totally new thing for you, as you said. Politics must have been another aspect of that? How did that happen?

Elders: I think you're absolutely right. Politics was very different. I had to go to college and medical school. I was in basic lab research. Then I was asked to be the

director of the Department of Health for the state of Arkansas. That was when I really went out in the country and truly *learned* public health. Before that I knew from all my experiences.

That was while Bill Clinton was governor. I went all over the 75 counties of Arkansas, and I saw what was going on. Every night, I would just go home being depressed in seeing the problems that were going on in Arkansas, feeling that we've got to do something about it, and thinking about the things that we could do, and we had to do in order to make a difference. A big thing I was involved in, in the beginning, was teenage pregnancy. I said we can't keep having children who are poor, ignorant, and slaves. And I outlined a program: This is where we've got to start.

Courtesy of Kirk Meighoo

Official Photo

Dr. Joycelyn Elders, a former U.S. Surgeon General, a professor emeritus of pediatrics at the University of Arkansas for Medical Sciences, and an initiator of the Committee for the Coincidence of Opposites.

Meighoo: And when Bill Clinton became President, he brought you in as Surgeon General.

Elders: I had been his health director for six years.

Meighoo: Fascinating! How about you, Dr. Gopeesingh? Your story may not be all that different, if I understand correctly.

Gopeesingh: I was born in the late 1940s, and shared part of Dr. Elders social pathway. I was the last of my mother's children. She had 13 pregnancies, but I was the 8th one who remained alive; I was the last. I grew up in very humble beginnings. My father was a worker in an oil company. He would do laborious work to earn his life's work. My mother was at home. My mother could not read nor write. she was a functional illiterate. But she wanted to try and educate her children. My mother vowed that I must be doctor one day; saying in the Hindi language, "You must be a doctor later." Those were her words. So, I got educated. I went through the primary school system, then to Naparima College in San Fernando; repeated A levels to see if I could get a scholarship. And worked for three years before going to the University of the West Indies to do medicine. Played a lot of cricket during that time; played national cricket. On two occasions, I represented Jamaica in cricket. I wanted to do sports medicine because I was involved in that. But when we had to open the Mount Hope Women's Hospital… [the minister and our professor] both said to go to Mount Hope. But he did not have a team, so three of us went up to England to train at the Institute of Obstetrics and Gynecology.

Meighoo: The Mount Hope Hospital, for our international listeners, is the largest hospital in Trinidad and Tobago, and in the English-speaking Caribbean, if not beyond. It was a massive project. It was built out of the first oil boom we had in the 1970s, so that was one phase of our medical expansion of infrastructure, and you were a part of that.

Gopeesingh: That's right. It was one of the largest complexes in medicine, built between 1981 and 1985. We had two hospitals; they were old hospitals built in the colonial days—San Fernando General and the Port-of-Spain General Hospital with the five-block unit—the medical sciences complex, named for the former prime minister. I had to open the pediatric part of the hospital, because when I was chairman of the Northwest Regional Health Authority, I moved the pediatric wards across to the Eric Williams Medical Sciences Complex. Then, we evolved into becoming the University of the West Indies, Trinidad Aspect. We started the Clinical Sciences in Trinidad in 1987; we had the first graduates in 1993-94. So, the medical faculty of Trini-

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Trinidad and Tobago Minister of Health, the Honorable Terrance Deyalsingh, chats with a patient at the Mount Hope Women's Hospital during his tour of the Neonatal Intensive Care Unit, October 28, 2015.

dad is now about 30 years young; whereas the University of the West Indies medical faculty started in the 1950s under the Royal Charter.

Meighoo: To interject, for our international listeners, the University of the West Indies is a unique university. It's multinational. It's in different countries and on different islands in the West Indies that are separate countries—Jamaica, Barbados, Trinidad. Jamaica had the medical facility.

Gopeesingh: Yes, before in the 1950s, it started there. But we had off-campuses do clinical medicine in the different countries—Barbados and Trinidad. Then we opened up the one in the Bahamas in 1999. There was a hospital. Then later we became part of the medical school. Barbados has its own medical school now, but we have a common syllabus and a common examination amongst the four campuses of the University of the West Indies.

That's where I really began. I did my post-graduate work at the University of London in three hospitals—Thomas Pitt, Jersey Hospital for Women, and Queen Charlotte Hospital where the royal family went. In 1982, I went up to Johns Hopkins University in the United States to do academic skills and reproductive medicine. In 1988, I went to the Royal College of Physicians and Surgeons in Canada to do the gynecological oncology part. I was the first non-Canadian to be trained in the program in gynecologic oncology in Canada, in Toronto in 1980. When I came back, I did gynecological oncology, and still do, and obstetrics. I became Clinical Dean in 1994, and we had to ensure that the medical faculty became self-sufficient. Then I was…[also] at the associate professor level in 1993.

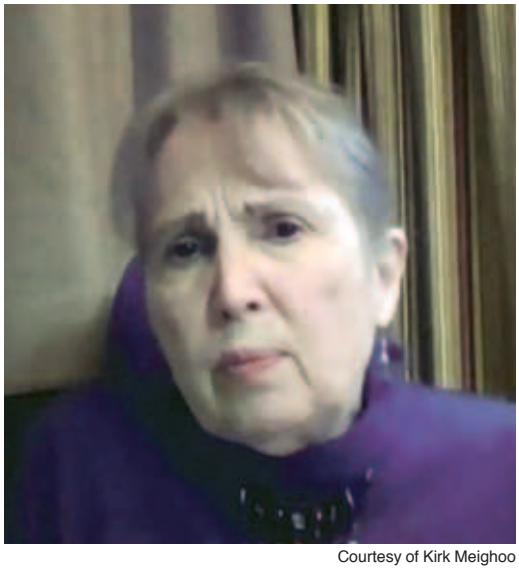
When I worked in the hospital, what got me into politics is—we were trying to help in the management of patients and improve health care. But within the medical faculty, you are limited. You can't do as much as you would like to do, so I decided that at some time I will want to be in a position where I could assist. That's when I was approached to join the political side. I thought from a technical perspective, I would help in improving health care. But I got more and more drawn into the politics, and this is when I began to serve as chairman of the two of the four Regional Health Authorities in Trinidad which started in 1993. I joined in 1997. Then I was deputy chairman of the National Advisory Committee on Education in 1997.

I had to complete a national training agency with a number of my colleagues in 1996-97 as well. Then I was appointed as Senator in 2001. Then, we both lost the election, we came back as a temporary Senator and a full Senator. Then I came back into the Parliament as an elected member in 2007. I served there for 15 years, once in the Opposition from 2007-10; in government as Minister of Education 2010-15. I also acted many times as Minister of Health. Prime Minister Panday had appointed me as Minister of Integrated Planning and Development in 2001 in the absence of John Humphrey.

So, the political sojourn has been long, but I retired from representative politics at the end of the last 11th Parliament in Trinidad. I served in the 7th and 8th; I think I skipped one. In the 10th and 11th Parliaments, I was in both the Senate and in government as a minister.

But my whole life really has been medicine. I really love medicine. I taught over 3,000 young medical stu-

dents. I have been instrumental in training over 50 post-graduates. I wrote about 33 papers for international scientific journals. I made scientific presentations in 40 cities around the world and contributed some chapters to medical textbooks. Now, I'm trying to work on the overall aspect to see how we can improve medicine and education. These are my core technical abilities—medicine and education. So, I look forward to continuing.



Courtesy of Kirk Meighoo

Marcia Merry Baker, Economics Co-Editor of EIR.

Meighoo: That's really great, from both Dr. Elders and Dr. Gopeesingh. They come from rural backgrounds, very underserved compared to the rest of the population in Trinidad and in the United States. And both of you broke barriers, being the first in many fields; that's amazing.

Now Marcia, you also come from a rural background, is that correct?

Merry-Baker: No, I'm a split personality. It's half-correct. I happened to be born in Pennsylvania, two blocks from the U.S. Steel Tube Works in McKeesport, near Pittsburgh. But on the other side of the family, my father ran a dairy, bought milk from 600 dairy farmers in Pennsylvania, and helped organize the first dairy farmer cooperative in the whole state on the day of my birth in 1943.

So, I think infrastructure was my watchword when I was growing up, because Pennsylvania was the home of steel at the time. I was born during World War II, and it was full of smoke and full of production. The same with the dairying. I know a lot about cows and dairy processing.

But infrastructure was all over; I didn't know anything else when I was young. The first commercial nuclear power plant was near me in western Pennsylvania in 1956. I took for granted many things like bridges. Pennsylvania has the largest number of bridges per unit area in the world with all the rivers. I didn't know any better, and I was very interested in this. Also, I came to know that at the same time, internationally, there were these famous infrastructure commitments like Atoms for Peace. That was under Eisenhower. And you had Food for Peace, sending food where needed. And you had, under Kennedy, the Alliance for Progress in the Americas. All this made sense to me, but I think I could say the Vietnam War opened my eyes that there was a different outlook in the world that fostered wars and fostered conflicts. As we can say today in Syria and Yemen; this is wrong.

Also, what happened is, at the time—that was in the 1960s—I saw many of the people I looked up to, assassinated: President Kennedy; Dr. Martin Luther King; Robert Kennedy; Malcolm X. So, I became very worried with what was happening in the world. When it came to Vietnam, I heard a man—Lyndon LaRouche, an American—say Indochina could be the Rice Bowl of Asia instead of war in Vietnam. I knew that for a fact; I knew about agriculture. So, when he said we should have an International Development Bank in 1975, I thought, well that makes sense. In 1976, I was chairman of Mr. LaRouche's run for President of the United States. We put him on the ballot in 26 states; enough that had we had the vote—we did have a big vote in the Dakotas—you could win. So, it was a serious policy challenge.

So, fast forward, I have been very committed to fight for infrastructure and the policy behind it: that everyone and every nation should have the physical, and also cultural and scientific means for advancement.

I've been in some big fights. With Dr. Elders, I was in the fight in Washington, D.C., that we should keep open the District of Columbia's General Hospital. There was a financial crowd, after the 1970s internationally, that said free markets and floating currencies and this kind of financial policy should rule, not nation-building with infrastructure.

The Washington, D.C. General Hospital was actually shut down in 2001. We fought against it with many physicians—Dr. Walter Faggett, Dr. Seymour, and many others. This hospital had over 500 beds. It had a quarantine wing; it was full-service, and served Washington, D.C.'s constituency, and many poor people had full service. And it was shut down. So, that's what happened after the 1970s. There was a takedown; there was a ceasing of infrastructure building.

I was interested early on, in the Caribbean. I didn't

know much, but Eisenhower in 1956, finished, for example, the Péligree Dam on the island of Hispaniola and the Artibonite River in Haiti. I thought then as a young person that that should be the way the world should go. It turned out to be a big fight and look where we are now with the pandemic. That's our fight now.

Meighoo: Dr. Elders, you were a co-initiator of the Committee for the Coincidence of Opposites. Can you explain how that happened, and what you all are advocating?

Elders: The Committee has really been working very hard. It's more the brainchild of Helga Zepp-LaRouche, that is the forming the Committee. But the rest of us have gotten together; we thought it was a great idea, and we have worked together. We feel very strongly that we should work with others from many different areas, many different backgrounds. We need to work together to make sure that everybody in the world has things that are essential for life. We need to make sure that everybody has healthcare. We don't need a tertiary hospital everywhere where we can do heart transplants, but we need to have basic public health.

We've got to make sure that everybody has food. If you don't have food, there's no way you can be healthy. I can't be worrying about taking care of your health. We have to be worried about education. You can't educate children if their stomachs are growling. If there's no food, we've got to make sure of that. We've got to make sure that we've food, clothing, and shelter; make sure we have clean drinking water.

Some of these things we're able to really put together and do fairly quickly. Others are far more complicated. You can't train a neurosurgeon overnight; but we can talk about training some of the community health workers. Young people who can work in the community and could really do things to make a great difference in the health of that community. They could take blood pressures, blood sugars, things that would really make a difference in keeping people healthy and making sure we knew who had food; that they knew about the best that they had to offer in terms of housing. That was kind of our idea. We want everybody to have excellent, super health. We want them all to have good doctors and the best health possible. But we can't, if we don't have the very basics. We can make sure they have the best they can possibly have, and that it is being used as effectively as it can be used.

Meighoo: In reading the news over the past couple of days, that perspective really stood out to me more, because in Africa, for example—and this ties into some of the politics here in Trinidad and Tobago—in Africa right now, there are about 2 million vaccine doses that are about to be destroyed because they received them from the COVAX facility, but they are about to expire. Some of it is from vaccine hesitancy, but some of it is, that they don't have the infrastructure to deliver the vaccines throughout their countries. That is not just a matter of having medicine and vaccine to disseminate, but it's about having a health infrastructure in the countries. I think that's exactly the type of thing you're talking about, isn't it Dr. Elders?

Elders: Absolutely! There are just very basic things that we can try and make sure that it's there in every country. As I said, we don't have to be able to do heart transplants everywhere, but we need to be able to give the immunizations. We need to make sure people know about it. So, we've got to educate the people there. Work on building up the very basic infrastructure to make sure that we can do what we can and use what we can use. And have the people there do the things that they can do.

Meighoo: Dr. Gopeesingh, you were involved with the establishment of Mount Hope, which is a major hospital in the Caribbean, and here in Trinidad and Tobago. But also, while you were a cabinet minister, and sometimes Acting Minister of Health, you were a part of the government that had this *massive* expansion of health facilities that have now become so important in the parallel health system in treating COVID patients. There was even some resistance to that investment going on here.

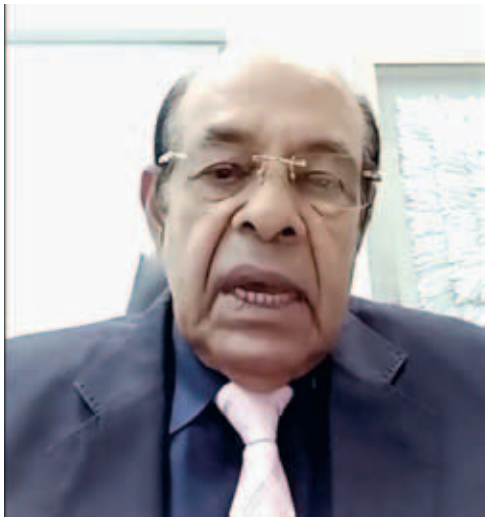
To tie it in to what Dr. Elders was saying, I have a story. When V.S. Naipaul was here around 2008 or so, we were talking, and he was telling me that the care he got in Trinidad blew him away. He said it was better than what he would have gotten in the U.K. He was very surprised. He grew up here in the 1950s, and then saw how things had changed by the 2000s.

The Children's Life Fund was a very important aspect of the government you served under, Dr. Gopeesingh. There were some procedures that we could not provide locally, but there was a fund set up by the government to send children to those specialist institutions. This was all part of this massive transformation of the health system, which, when we bring in the politics, un-

fortunately when the government changed, these things got scaled back. Could you elaborate?

Gopeesingh: Yes, certainly. We have two general hospitals for this—Port-of-Spain and San Fernando, which serve the North and Central. But with the erection of the Mount Hope Medical Complex, which…along with the Eric Williams Medical Center Complex, there began a little transformation into more sub-specialties of the Department of Medicine.

It started with a medical school coming on, and when you're teaching in hospital, the standards improve, from the time you begin to teach young doctors and post-graduates. We have been very fortunate: We train more than 300 doctors per year in the Caribbean…Jamaica about 120 per year, and Trinidad has in the last few years has had about 150. We train students from outside of the Caribbean as well. And from some of the Caribbean countries, they go with us.



Courtesy of Kirk Meighoo

Dr. Tim Gopeesingh, a former cabinet minister in the government of Trinidad and Tobago, a former Clinical Dean of the Faculty of Medical Sciences at the University of the West Indies, and a gynecologic oncologist.

But we have a parallel health system, one is public, and one is private. We have a number of district health facilities which service the districts from different places and different parts of the country. As you rightly said with the construction of the Couva Hospital, which we completed during Mrs. Kamla Persad-Bissessar's time as Prime Minister. And then the start of construction of the Point Fortin Hospital and the Arima Hospital—these are outlying hospitals—this has improved the ability to capture the population in these remote areas. The San Fernando Teaching Hospital as well. And also, the construction of one or two additional district care facilities.

So, we opened up the bed population by close to 1,000 beds, during our period of time. We improved training for nurses. We improved training for medical, and so it was a training program concomitant with the medical personnel expanse sector. We have about 10 private smaller hospitals, but they do a number of advanced surgical procedures, and they help with these. So, we have a system where, similar to England, where the state pays for the population that is unable to afford private health care, some who can afford private health care go into the private institutions; but you have basically the same medical and nursing personnel that move across both.

We did an analysis of the real problems facing the country, and the disease process is not a medical disease, which is experienced across the world—of diabetes, hypertension, cardiovascular disease, and with strokes and heart attacks, and so on, and also cancer. We have in our country about 18,000 births per year, about 11-12,000 deaths, an equal number of men and women. The leading cause of death in Trinidad in men, is heart disease, and heart attacks, strokes; next is prostate, hypertension, and then cancer. And the commonest cause of death in women is cancer, and then the other things follow—heart disease.

So, we have to continue to make an impact on the reduction of noncommunicable disease by the prevention, and early diagnosis and treatment to prevent the major complications of these, diabetes, hypertension; and what you do, you prevent things like kidney failure, you prevent heart attacks, you prevent strokes, you prevent blindness, you prevent amputations.

And as Dr. Elders—who is a professor of pediatrics—would understand, these are some imperatives that you have to work with to prevent the complications. Because most of the beds in the hospitals are filled with patients with complications of these disease processes.

And then, cancer is another one, where we have now moved ahead to get the necessary infrastructure, equipment and so on, to have diagnoses of cancer in earlier stages, and we have more and more doctors being trained now to manage the cancer patients, with radiotherapy, chemotherapy, or general surgery. So generally, I think we are at a good level. It could be improved.

I heard Dr. Elders mention the issue of teenage pregnancies and so on, which wreak havoc with other social problems. And since 2007, I have been speaking about the need to put a lid on that, because when the research came out from the Central Statistical Office, it showed more than about 2,500 teenage pregnancies per year, and when I was going to start education, we had a number of teenage pregnancies in the secondary schools,

so we have to work from a social perspective to have to reduce that amount; we have to work in the health sector from a preventive aspect, and we have to work from an education sector, to help to, as our colleagues manage, educating the general population. But we have a high percentage of single mothers who are struggling to make ends meet and so on, and so this is part of where the difficulty comes in, in terms of the social aspect. And of course, now, within the last few years, there has been some massive unemployment, which gives rise to many more problems as a result of the COVID.

Meighoo: Dr. Gopeesingh, when you look at the expansion of our facilities—because there are limited bed spaces and so forth, we see pictures in our press here in Trinidad and Tobago, of people lying on the floor—this was way before COVID started we were having these problems. So, the Eric Williams Medical Complex that we spoke about was done in 1981, and then, after that, the next major expansion waited until 2010—that's 30 years! And it needed a change of government. In fact, our first Eric Williams Medical Science Complex was riddled with corruption, and it became a huge political issue with the amount of corruption in that! And then, from 2010-2015 under the People's Partnership government led by Kamla Persad-Bissessar, who was our first female Prime Minister, we had this massive expansion.

And then, when the new government came in, they kept the hospital closed! This is mind-boggling why they would do that, and it's only when the COVID crisis hit that they eventually opened it up. They were talking about "debt" and "debt to China." That was the excuse, and they used that. And then, actually, a lot of the lack of investment in the '80s and '90s had to do with our economic situation, the downturn, how we went to the IMF, we had structural adjustment, and we stopped investing in infrastructure.

I'd like you to address that in the Trinidad context; and Marcia, I'd like you to address that in the international context, about the lack of investment in infrastructure, very often because of structural adjustment policies.

Gopeesingh: The physical infrastructure now, as you said, really had a boom during the People's Partnership government in 2010. These three new hospitals, and one or two district facilities have been built as a result of the investment by the People's Partnership under Mrs. Bissessar as Prime Minister. The present administration and government is able to use these facilities now to help with the management of COVID patients.

But in the health sector across the world, and more so in Trinidad, we need expertise and health care management. This is what we need to find, and we're not finding the…personnel to move into hospitals, and so on, to help with the proper management. [There was an experiment] with something in 1994, under the former Prime Minister, with Regional Health Authorities, to create four RHAs and put up one in Tobago.

We followed the British pattern. But that has been debated and the British system has changed about three or four times subsequent to that, and we are still holding on to RHA's, which is not working properly—bad management—although health, as our colleagues know, and Dr. Elders will know, is like a bottomless pit. The more money you pump into it, the more falls out.

The real issue is management. With few exceptions, Trinidad and Tobago, unfortunately, with 40-something years of one PNM (People's National Movement) governance, in their time, have never had a good Minister of Health to run the country properly, as far as the health sector.

So, they were fiddling from administration to administration. During our government, under Kamla Persad-Bissessar, we had ministers of health who knew the system, who knew about health care, and we were able to make some significant gains with it.

But, as you mention, when you make gains, when a new administration comes in, most of those gains are reversed. It happened in Education. When I was Minister of Education, the next government that came in in 2015 reversed almost *all* the wonderful policies and programs for the benefit of our students.

Meighoo: They built 116 schools, or something like that.

Gopeesingh: We became one of the first countries in the world to have one laptop per child. We gave out about 97,000 laptops to teachers, to students. They stopped all of that. We had a nice program for continuous learning, a Continuous Assessment program, to move students from a primary school to a secondary school over a three-year period. You assess the students. That would have given rise to students participating in the education, not reaching Standard-5, but three years before, and moving on to greater things.

So, in Trinidad and Tobago we have a lot more work to do. We need proper management. We need a govern-

ment that is committed to working and to improving standards all across. We had a formidable team in 2010-15. We made significant advances in almost every discipline and every area under Mrs. Bissessar... She allowed her ministers to work competently and *smartly*. Some people say you work hard, but our government worked smartly, and we were therefore able to achieve.

With this COVID though, there are a lot of weaknesses in the program. We did not get the number of vaccines that we should have had by now. There are a number of areas, gaps, that have to be closed. And so, to prevent the number of deaths that are occurring now, we have to move smart and swift to stop that.

I would like to ask Dr. Elders: I remember in the early 1990s, under President Clinton, he had appointed a team, under Mrs. Clinton, to bring about a report on the state of health care in the United States, bearing in mind that there were too many consultants and doctors at the higher level, and not enough general practitioners to look after the interest of the communities, as Dr. Elders has been speaking about. She is a pioneer on that, as we heard a while ago. That was what brought her to become Surgeon General.

I don't know what has happened to that. If Dr. Elders can give us some little on the subject, I would appreciate it.

Elders: Just a brief note. What we said was that there were too many specialists and not enough generalists, and we need to focus on health. In the United States we've got the best *sick care* system in the world. The problem is, we don't have a *health care* system.

A part of that, I think, is related to, as Dr. Gopeesingh has been saying, that's related to *leadership*—politics, policies. If the world's leaders would come together, we could begin to really look at what we could do to keep people healthy—get all the millions and billions of people in the world to improve their health. But you can't keep ignorant people healthy. So, we've got to educate people, so they can know how to take care of their own heath and know what to do about their own health.

We've done wonderfully in research; we've done a lot of good things. But we've got to involve *all* of our people in making sure that everybody does what they can do to improve their own health, and that all of our nations are operating at their top capacity. I think that is what we talked about. We haven't really made much progress in having more generalists. All I can say is that we've been working on it. We still have too many specialists, but that's our system of paying for medicine: paying for health care really supports the specialists, and not the generalists. It supports sick care, and not health care.

Meighoo: That's fascinating! To bring up issues of leadership; to bring up issues of economics, in both contexts that are working at a global level… I know, definitely for us, during the [IMF] structural adjustment period and our long recession in the 1980s, we stopped investing in roads, in schools, in hospitals, and all sorts of things. And it was only much, much later that we started.

This is not a unique experience of Trinidad and Tobago, is it? This is part of the whole sort-of debt system, the IMF, this kind of thing.

Merry-Baker: Yes, it's like systematic evil, not just individual, unfortunate corruption, or limited leadership, which we know about. You could say that we've had a world casino economy that's been specializing as a monetary system in debt, and adjustment, and austerity, and not in infrastructure.

In the mid-20th century—we've referred to the 1946 hospital act called the Hospital Survey and Construction Act. It was only nine pages long, by the way. It said that for all 3,000 counties in the United States, whether it's Arkansas, or Massachusetts, for the local residents, they should have a natal unit in their hospital, they should have some beds, and certain other modern facilities. As Dr. Elders said, they didn't need brain surgery everywhere.

Internationally, fast forward to today. The pandemic shows the principle in that. Dr. Gopeesingh has described the buildup period in Trinidad and Tobago. That's what we should be having, in all regions of the world. There is no other way to deal with this pandemic or the next outbreak.

There are initiatives in the right direction. In the Caribbean, it is impressive what Cuba is doing in the research for vaccines. We've also had the political vaccine initiative, where several Honduran mayors asked the President of El Salvador to please give them some vaccines that El Salvador was getting from China or wherever. And this was done. Argentina and Mexico have announced collaboration and will be collaborating to manufacture vaccines.

So, the principle that Dr. Gopeesingh described of the University of the West Indies, working together, building and teaching in health centers, but doing what Dr. Elders says. Public health measures can work.

Someone can come along and say, "But, you don't have the steel for the hospitals." Or cite some other restriction. Well, that's the point, isn't it? Launching health care infrastructure pre-supposes we're also going to work together to restore general production again.

And that's why I'm very glad to work with the Committee for the Coincidence of Opposites on the whole range of measures—the emergency delivery of food, for example. We have 12 million people just in Haiti and Honduras and Guatemala, some of the displaced Venezuelans, who need emergency food.

We should do all the emergency measures of food, vaccines, and so on, and then get back to work building the water systems, the hospital systems for the longer term.

One special note on the enemy we are up against, which I mentioned already as the wing of Wall Street that opposed public good infrastructure in order to "save money." Dr. Elders knows about this. That happened on a large scale in the U.S. Beginning in the 1970s and '80s, public hospitals in the U.S. were sold off for private profiteering. The insurance companies expanded to become the private arbiter of whether you get treated or not. There's a lot of money involved, but it isn't going to pay for health care.

But the latest enemy evil is the green menace. There's a green bubble that's being attempted by the monetarist financial system—Wall Street and the City of London—that says "Don't develop your resources or infrastructure. You go primitive and sell your carbon emission credits to a new carbon market we're creating." The former Governor of the Bank of England, a stinker named Mark Carney, in April, said that's what Africa should do as a continent: do not develop your resources and transport and everything; instead, you must sell carbon credits for not emitting anything.

The famous English medical journal, *The Lancet* said in 2019 that health care, if it's expanded throughout Africa and to billions of more people in the world, will overheat the Earth! We have to stop this green craziness!

Meighoo: I have to agree with those aspects, definitely. Dr. Elders, how has the COVID crisis exacerbated or magnified these issues?

Elders: When we look at and think about the COVID crisis, I think one of the things that we have to be aware of, is that the COVID crisis has exposed the weak underbelly of all of the things we're talking about. All of these problems have been out there for a very long time. Now, COVID has made us talk about them, especially in *every* country, not in just the less-developed countries, and made us realize that we can't heal ourselves without healing the rest of the world. Because it just may come back.

I feel that when we look and think of how we're going to think about leadership, I think of what I call the "Five Cs of Leadership."

COVID has made us *come together* and begin to visualize that we've got a problem. It's made us realize that we've got to be *consistent*. Dr. Gopeesingh mentioned how governments would start and really develop something and have a good thing going on, but somebody else would come in and cut it off, and we start all over again. So, we've got to have a vision, and be consistent at making it go. We then must be sure we're *competent* to get the job done. We've got to have competent people around to get the job done. We've got to be *committed* to make it go on forever. Of course, we've always got to have somebody to keep *control*.

COVID has made us at least come together to think about it. Before, I think we were just going our separate directions and we really didn't think about it. I hope we take the lesson we've learned, take off our blinders, get 20-20 vision, and start looking at what we can do to improve the health of the world, realizing we're not going to improve our own health, until we improve everyone's, and until everybody knows how to prevent the crises we get into.

Meighoo: I love that, and I love those five Cs. They're a really great summary of that. Dr. Gopeesingh, how has the COVID crisis exacerbated or illustrated this from your perspective?

Gopeesingh: The first issue is that it's a viral infection that has struck the world. The world's leaders and the WHO are still trying to grapple with the etiology or causative factor. And until that is known, we stand a chance of having repeat viral infections, from the SARS, the MERS, to COVID-19, to what else is coming subsequently.

As the common cold virus mutates, and you have to get a new vaccine almost every two years, what is going to happen if this virus continues to mutate, and you have to get vaccine for seven billion people around the world? I hope the scientists come up with an answer to that. I see that there are companies now looking at a nasal spray to offset the massive cost and the massive problems associated with the production

and administration of the vaccine across the globe.

There are basic underlying issues which we have to solve, in terms of prevention of this disease coming forward. What was the etiology or causative factor for *this* virus? We still haven't found out. And how do you work to prevent something like this happening? As a young doctor in the 1970s and early '80s, we saw the emergence of the HIV virus, and now, 2021, 40 years later, we have not found a vaccine for the HIV virus. HIV has killed a significant number of people around the world. But medical science has brought on new drugs and pharmaceuticals to help with that, and to prevent demise, so some people could lead a normal life with the pharmaceuticals.

Now, where are we with COVID? We can have all the infrastructure, all the money. We could vaccinate the entire population to bring herd immunity, and so on, but you have to think about the future and the continued emergence of what some people describe as "variants," but I say it's a mutation of the virus itself, which keeps on mutating. Because it *did* mutate from SARS to MERS to this COVID-19.

All the virologists, all the infectious disease people around the globe will have to grapple with that, because we are a county that will depend on the international work that has to be done. And the Surgeon General will probably be looking at that, from the perspective of the economics.

Meighoo: What you're talking about is the science and research, and the development, which *has* to be part of it. It can't only be about delivery, but has to be the *thinking* part of it, the anticipation of it. Marcia: Is there anything you would like to add. I think Drs. Elders and Gopeesingh gave a nice sum.

Merry-Baker: I think they said it all, and this should be the agenda for us, pushing the major-power leaders. China and Russia are already getting together. We should set the agenda and that should be what just was described. It's kind of an Apollo program that we had 52 years ago. We can do this!

Excellent, excellent. I want to thank you *all* for this fascinating and interesting discussion. It's really been a pleasure having you on the program.